TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Alejandro Martinez MD

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-4151-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed using the correct coding initiative of billing CPT code 95913 with 95886 and 95887 as part of the procedure dated 5/27/15."

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2015	95886 -59, 95887	$450.00	$200.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
   - 297 – This procedure code is only reimbursed when billed with the appropriate initial base code
   - B24 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 107 – "Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim" and 297 – "This procedure code is only reimbursed when billed with the appropriate initial base code." 28 Texas Administrative Code §134.203(b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;."

   Review of the submitted information finds:

   - 95886 - Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)
   - 95887 - Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

   Further review of the submitted medical claim finds the requestor submitted 95913 – "Nerve conduction studies;" The Division finds the requestor submitted a valid claim with the primary procedure being 95913 and the "add-on" procedures 95886 and 95887. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203(c) states,

   - Procedure code 95886, service date May 27, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.92 is 0.3772. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.822 is 0.02466. The sum of 1.26186 is multiplied by the Division conversion factor of $56.20 for a MAR of $70.92 at 2 units is $141.84.
   - Procedure code 95887, service date May 27, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.71 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.71. The practice expense (PE) RVU of 0.34 multiplied by the PE GPCI of 0.92 is 0.3128. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.822 is 0.02466. The sum of 1.04746 is multiplied by the Division conversion factor of $56.20 for a MAR of $58.87.

3. The total allowable reimbursement for the services in dispute is $200.71. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $200.71. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $200.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $200.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.